APPLICATION FOR INITIAL CLINICAL PRIVILEGES AND STAFF APPOINTMENT

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority:	Title 5, United States Code (USC), Sections 301 and 552a; Title 44, USC, Section 3101; Title 10, USC, Section 1071.
Principal Purpose:	To document the provider's professional qualifications as the basis for clinical privileges and staff appointment.
Routine Uses:	To support the credentialing and privileging processes. A copy of this form will be retained in provider credentials file. Information may be provided to certain civilian institutions, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulatory bodies.
Disclosure:	Disclosure of information requested is voluntary. However, failure to provide the required information may interfere with the timely granting of your clinical privileges or professional staff appointment.

INSTRUCTIONS. This form is to be completed by all providers (military/civilian) who are first time applicants for clinical privileges and for *initial* medical staff appointment, if requested. Initial staff appointment is granted on the occasion of the provider's first assignment/ employment at a DoD MTF, or if there has been a lapse in DoD MTF appointment status of greater than 180 days, e.g., the provider has been involved in civilian training program.

SECTION I - IDENTIFICATION

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. SSAN	4. DATE OF BIRTH *(YYYYMMDD)*

5. SPECIALTY/AOC	6. MEDICAL/DENTAL FACILITY *(Name and Address: City/State/Zip Code)*

SECTION II - PROFESSIONAL EDUCATION

7a. COLLEGE OR UNIVERSITY	7b. LOCATION *(City/State)*	7c. DEGREE	7d. GRADUATION DATE *(YYYYMMDD)*

SECTION III - POSTGRADUATE TRAINING

8a. HOSPITAL OR INSTITUTION	8b. LOCATION *(City/State)*	8c. PROGRAM *(Residency, etc.)*	8d. COMPLETION DATE *(YYYYMMDD)*

SECTION IV - PREVIOUS PROFESSIONAL AFFILIATIONS *(Past 10 years. Continue on reverse in block 23.)*

9a. HOSPITAL OR INSTITUTION	9b. LOCATION *(City/State)*	9c. FROM/TO *(YY/MM-YY/MM)*	9d. DEPARTMENT

SECTION V - BOARD CERTIFICATION/PROFESSIONAL SOCIETY MEMBERSHIP

10. Are you eligible to take your board examination? ☐ N/A ☐ NO ☐ YES *(If YES, indicate specialty in block 22.)*

11. Have you taken your boards? ☐ NO ☐ YES *(If YES, note date.)* _____ ☐ TOTAL ☐ PARTIAL

12. Are you ABMS board certified? ☐ NO ☐ YES *(If YES, indicate specialty in block 23.)*

13. Memberships in Specialty Societies. *(List all active memberships.)*

SECTION VI - LICENSURE/CERTIFICATION/REGISTRATION. *(Include all current and previous states of licensure.)*

14a. STATE OR AUTHORIZING AGENCY	14b. LICENSE NUMBER	14c. EXPIRATION DATE *(YYYYMMDD)*

SECTION VII - CONTROLLED SUBSTANCES REGISTRY

15a. DEA OR CDS NUMBER	15b. STATE OF ISSUE *(If applicable)*	15c. EXPIRATION DATE *(YYYYMMDD)*

SECTION VIII - CLINICAL PRIVILEGES REQUESTED

16. I attest that based on my professional qualifications and credentials, I am clinically competent to fully perform the clinical privileges for which I am applying. I request privileges in the following disciplines:

17. I request privileges in the following category: *(Check one.)*
☐ Regular ☐ Temporary ☐ Supervised

18. I request admitting privileges.
☐ YES ☐ NO

19. I request to manage and treat patients in age groups: *(Check all that apply.)*
☐ Neonates (Birth - 28 days) ☐ Infants (1-24 mos) ☐ Children (2-12 yrs) ☐ Adolescents (13-17 yrs) ☐ Young Adults (18-23 yrs) ☐ Adults (24-65 yrs) ☐ Geriatrics (> 65 yrs)

SECTION IX - STAFF APPOINTMENT REQUESTED

20. I request initial appointment to the medical/dental staff of this health care facility. ☐ YES ☐ NO

SECTION X - OTHER

21. Do you possess ECFMG certification? ☐ N/A ☐ NO ☐ YES *(If YES, note date of issue.)* _____

22. Which of the following do you possess? *(Check all that apply.)* ☐ BLS ☐ ACLS ☐ ATLS ☐ PALS ☐ Other *(specify)* _____

SECTION XI - COMMENTS

23. Provide explanation or additional details for any of the numbered items above. *(Note item number.)*

24. I hereby certify that the information contained herein is true, accurate, and complete to the best of my knowledge.

	24a. SIGNATURE OF PROVIDER	24b. DATE *(YYYYMMDD)*